NATIONAL GUIDELINE CLEARINGHOUSE™ (NGC) GUIDELINE SYNTHESIS

SUICIDAL IDEATION AND BEHAVIOR: MANAGEMENT

Guidelines

1. **American Psychiatric Association (APA)**. Practice guideline for the assessment and treatment of patients with suicidal behaviors. Arlington (VA): American Psychiatric Association; 2003 Nov. 117 p. [846 references]
2. **New Zealand Guidelines Group (NZGG)**. The assessment and management of people at risk of suicide. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 May. 72 p. [89 references]

INTRODUCTION:

A direct comparison of the American Psychiatric Association (APA) and New Zealand Guidelines Group (NZGG) recommendations for management of individuals with suicidal ideation and/or behavior is provided in the tables, below. The APA guideline contains general and specific recommendations for assessment of the patient, psychiatric management, specific treatment modalities and documentation and risk management issues. In addition, it includes an overview of suicide, its natural history, course and epidemiology; a structured review and synthesis of the evidence underlying the APA recommendations; and a summary of areas for which more research is needed to guide clinical decisions. Only recommendations related to psychiatric management of individuals at risk for suicide are addressed in this synthesis. The NZGG guideline replaces a 1993 guideline developed by the New Zealand Department of Health. Its recommendations are intended for use in emergency department and acute psychiatric service settings and therefore focus primarily on crisis and initial management of patients at risk for suicide. Both guidelines also address risk assessment of individuals with suicidal ideation and/or behavior. This topic, however, is beyond the scope of this synthesis. See the NGC Synthesis Suicidal Ideation and Behavior: Risk Assessment.

Both guidelines address management of suicidality in special populations. The APA guideline considers management issues in different settings, as well as management issues concerning the needs of certain cultural groups. The NZGG guideline considers the needs of children and adolescents, the elderly, Māori, Pacific peoples, people of Indian descent, Asian populations and refugee groups. The NZGG guideline also specifically addresses management issues for people at chronic risk for self-harm/suicide.

The tables below provide a side-by-side comparison of key attributes of each guideline, including specific interventions and practices that are addressed. The

language used in these tables, particularly that which is used in Table 4, Table 5 and Table 6, is in most cases taken verbatim from the original guidelines:

- Table 1 provides a quick-view glance at the primary interventions considered by each group.
- Table 2 provides a comparison of the overall scope of both guidelines.
- Table 3 provides a comparison of the methodology employed and documented by both groups in developing their guidelines.
- Table 4 provides a more detailed comparison of recommendations offered by each group for the topics under consideration in this synthesis, including:
    - General Recommendations
    - Pharmacologic Therapy
    - Electroconvulsive Therapy
    - Psychosocial Therapy
    - Supporting References
- Table 5 lists the potential benefits associated with the implementation of each guideline as stated in the original guidelines
- Table 6 presents the rating schemes used by USPSTF to rate the level of evidence and the strength of the recommendations.

A summary discussion of the areas of agreement and areas of differences among the guidelines is presented following the content comparison tables.

Abbreviations:

- APA, American Psychiatric Association
- ECT, electroconvulsive therapy
- GPP, Good Practice Point
- NZGG, New Zealand Guidelines Group
- SSRI, selective serotonin reuptake inhibitor

TABLE 1: COMPARISON OF INTERVENTIONS AND PRACTICES CONSIDERED
("✓" indicates topic is addressed)

	APA (2003)	NZGG (2003)
Management		
Determination of a treatment setting	✓	✓
Development of a treatment plan	✓	✓
Establishment of a therapeutic alliance	✓	✓
Discharge planning	✓	✓
Specific Treatment Modalities		

Pharmacological agents	✓	✓
Psychotherapies	✓	✓
Electroconvulsive therapy	✓	

TABLE 2: COMPARISON OF SCOPE AND CONTENT	
Objective and Scope	
APA (2003)	• To assist psychiatrists in the assessment and care of their patients with suicidal ideation/behaviors • To represent a synthesis of current scientific knowledge and clinical consensus
NZGG (2003)	To guide those working in emergency departments and in acute psychiatric services in the appropriate assessment and early management of suicidal people
Target Population	
APA (2003)	Adult patients with suicidal ideation and/or behaviors
NZGG (2003)	Children, adolescents, adults, and elderly persons in New Zealand who self-harm or attempt suicide or are at-risk for suicide
Intended Users	
APA (2003)	Physicians
NZGG (2003)	Advanced Practice Nurses Allied Health Personnel Emergency Medical Technicians/Paramedics Health Care Providers Nurses Physician Assistants

	Physicians Psychologists/Non-physician Behavioral Health Clinicians

TABLE 3: COMPARISON OF METHODOLOGY		
	APA (2003)	**NZGG (2003)**
Methods Used to Collect/Select the Evidence	• *Hand-searches of Published Literature (Primary Sources)* • *Searches of Electronic Databases* *Described Process:* Relevant literature was identified through a computerized search of PubMed for the period from 1966 to 2002. Key words used were "suicides," "suicide," "attempted suicide," "attempted suicides," "parasuicide," "parasuicides," "self-harm," "self-harming," "suicide, attempted," "suicidal attempt," and "suicidal attempts." A total of 34,851 citations were found. After	• *Hand-searches of Published Literature (Primary Sources)* • *Hand-searches of Published Literature (Secondary Sources)* • *Searches of Electronic Databases* **Note from the National Guideline Clearinghouse (NGC)**: *A systematic literature review was prepared by the New Zealand Health Technology Assessment (NZHTA):* • New Zealand Guidelines Group (NZGG). Search strategy. The assessment and management of people at risk of suicide. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 May 2 p. Available from in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site. *Described Process*: A systematic method of literature searching and selection was employed in the preparation of this review. Searches were limited to English language material published from 1990 onwards.

	limiting these references to literature published in English that included abstracts, 17,589 articles were screened by using title and abstract information. Additional, less formal literature searches were conducted by American Psychiatric Association (APA) staff and individual members of the work group on suicidal behaviors through the use of PubMed, PsycINFO, and Social Sciences Citation Index. Sources of funding were not considered when reviewing the literature.
	
	Number of Source Documents:
	
	• 34,851 citations
	• 17,589 articles
	
	Number of References: 846
		The searches were completed in April 2002 using bibliographic databases (MEDLINE, EMBASE, CINAHL, PsychINFO, Current Contents, Science/Social Science Citation, Index New Zealand) and review databases (Evidence-based medicine reviews, Cochrane Database of Systematic Reviews, DARE, NHS Economic Evaluation Database, Health Technology Assessment Database). Hand searching of journals or contacting of authors for unpublished research was not undertaken during the search process.
		
		Study Design and Sample Size:
		
		• Studies employing one of the following designs: systematic review or meta-analysis, randomised controlled trials, cohort study, case-control study
		• Studies contained samples of at least six participants.
		
		Study Exclusion Criteria
		
		The following criteria were used to exclude studies from appraisal:
		
		• study population concerned:
		  • primarily (50% or more) children 12 years of age and under
		  • homicidal people
		  • criminal offenders
		• studies concerned with:
		  • the treatment of people with drug/substance abuse or

		dependence (that is, treatment directed to their addiction rather than any suicide attempt) • suicide prevention interventions specifically for people with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) • school-based suicide prevention interventions • economic analysis • studies involving small numbers of case presentations (five or fewer cases) • studies not clearly describing their methods and results or having significant discrepancies • citations which were letters to the editor, comments, editorials, abstract only, or conference proceedings **Search Terms Used** MEDLINE subject terms (Medical Subject Heading [MeSH] terms): suicide, suicide attempted, exp self-injurious behavior, crisis intervention, emergencies, emergency treatment, exp antipsychotic agents, exp psychotropic drugs, exp antidepressive agents, exp tranquilising agents, psychopharmacology PsychINFO subject terms: suicide, self-destructive behavior, attempted suicide, suicidal ideation, suicide prevention, self-inflicted

		wounds, self-mutilation, side-effects drug, risk factors, risk analysis, exp drugs, drug therapy Additional keywords: suicid*, parasuicid*, crisis, crises, psychopharm*. *Number of Source Documents:* Not stated *Number of References: 89*
Methods Used to Assess the Quality and Strength of the Evidence	*Expert Consensus (Committee)*	*Weighted According to a Rating Scheme (Scheme Given — Refer to Table 6)*
Methods Used to Analyze the Evidence	• *Review of Published Meta-Analyses* • *Systematic Review with Evidence Tables*	• *Review of Published Meta-Analyses* • *Systematic Review with Evidence Tables* **Note from the National Guideline Clearinghouse (NGC)**: *A systematic literature review including evidence tables were prepared by the New Zealand Health Technology Assessment (NZHTA)* *Described Process*: Articles were formally appraised using the checklist schedules and hierarchy of evidence coding system developed by the Scottish Intercollegiate Guidelines Network (SIGN). Validated criteria were used to appraise the studies selected for review. Key facets of the selected studies (including limitations) were documented in the text. Conclusions were drawn based on the study design and the

		specific problems associated with individual studies. The evidence presented in the selected studies were assessed and classified according to the SIGN grades of guideline recommendation by the suicide prevention guideline group.
Outcomes	• Morbidity and mortality • Severity of symptoms • Rate of remission, relapse, and recurrence of suicidality	• Repeat presentations for suicidality • Repeat suicide attempts • Mortality from suicide
Methods Used to Formulate the Recommendations	• *Expert consensus (refer to Table 6 for rating scheme)* *Described Process*: Once a topic is chosen for guideline development, a work group is formed to draft the guideline. By design, the work group consists of psychiatrists in active clinical practice with diverse expertise and clinical experience relevant to the topic. Policies established by the Steering Committee guide the work of systematically	• *Expert Consensus (Refer to Table 6 for rating scheme)* *Described Process*: A Guideline Development Team drafted the recommendations. The team consisted of nominated representatives including: mental health clinicians (psychiatrists, psychologists), emergency department clinicians (physicians and nurses), consumers and family group representatives, Māori health advisors and Pacific health advisors. The draft guideline was circulated widely for external consultation.

	reviewing data in the literature and forging consensus on the implications of those data, as well as describing a clinical consensus. These policies, in turn, stem from criteria formulated by the American Medical Association to promote the development of guidelines that have a strong evidence base and that make optimal use of clinical consensus.	
Financial Disclosures/Conflicts of Interest	Potential financial conflicts of interest: This practice guideline has been developed by psychiatrists who are in active clinical practice. In addition, some contributors are primarily involved in research or other academic endeavors. It is possible that through such activities some contributors have received income related to treatments discussed in this guideline. A number of mechanisms are in place to minimize	Declaration of Competing Interests: Pete Ellis has accepted support from Janssen-Cilag to attend a recurring scientific meeting in New Zealand as a presenter and part organiser. Brian Craig has received travel support to attend an overseas conference from Janssen-Cilag.

	the potential for producing biased recommendations due to conflicts of interest. The guideline has been extensively reviewed by members of the American Psychiatric Association (APA) as well as by representatives from related fields. Contributors and reviewers have all been asked to base their recommendations on an objective evaluation of available evidence. Any contributor or reviewer who has a potential conflict of interest that may bias (or appear to bias) his or her work has been asked to notify the APA Department of Quality Improvement and Psychiatric Services. This potential bias is then discussed with the work group chair and the chair of the Steering Committee on Practice Guidelines. Further action depends on the assessment of the	

	potential bias.	

TABLE 4: COMPARISON OF RECOMMENDATIONS FOR MANAGEMENT OF INDIVIDUALS WITH SUICIDAL IDEATION AND/OR BEHAVIOR	
MANAGEMENT	
General Recommendations	
APA (2003)	**Psychiatric Management** Psychiatric management consists of a broad array of therapeutic interventions that should be instituted for patients with suicidal thoughts, plans, or behaviors **[I]**. Psychiatric management includes attending to patient safety, determining a setting for treatment and supervision, and working to establish a cooperative and collaborative physician-patient relationship. For patients in ongoing treatment, psychiatric management also includes establishing and maintaining a therapeutic alliance; coordinating treatment provided by multiple clinicians; monitoring the patient's progress and response to the treatment plan; and conducting ongoing assessments of the patient's safety, psychiatric status, and level of functioning. Additionally, psychiatric management may include encouraging treatment adherence and providing education to the patient and, when indicated, family members and significant others. Patients with suicidal thoughts, plans, or behaviors should generally be treated in the setting that is least restrictive yet most likely to be safe and effective **[I]**. Treatment settings and conditions include a continuum of possible levels of care, from involuntary inpatient hospitalization through partial hospital and intensive outpatient programs to occasional ambulatory visits. Choice of specific treatment setting depends not only on the psychiatrist's estimate of the patient's current suicide risk and potential for dangerousness to others, but also on other aspects of the patient's current status, including 1) medical and psychiatric comorbidity; 2) strength and availability of a psychosocial support network; and 3) ability to provide adequate self-care, give reliable feedback to the psychiatrist, and cooperate with treatment. In addition, the benefits of intensive interventions such as hospitalization must be weighed against their possible negative effects (e.g., disruption of employment, financial and other psychosocial stress, social stigma). For some individuals, self-injurious behaviors may occur on a recurring or even chronic basis. Although such behaviors may occur without evidence of suicidal intent, this may not always be the case. Even when individuals have had repeated contacts with the health

care system for self-injurious behavior, each act should be reassessed in the context of the current situation **[I]**.

In treating suicidal patients, particularly those with severe or recurring suicidality or self-injurious behavior, the psychiatrist should be aware of his or her own emotions and reactions that may interfere with the patient's care **[I]**. For difficult-to-treat patients, consultation or supervision from a colleague may help in affirming the appropriateness of the treatment plan, suggesting alternative therapeutic approaches, or monitoring and dealing with countertransference issues **[I]**.

The suicide prevention contract, or "no-harm contract," is commonly used in clinical practice but should not be considered as a substitute for a careful clinical assessment **[I]**. A patient's willingness (or reluctance) to enter into an oral or a written suicide prevention contract should not be viewed as an absolute indicator of suitability for discharge (or hospitalization) **[I]**. In addition, such contracts are not recommended for use with patients who are agitated, psychotic, impulsive, or under the influence of an intoxicating substance **[II]**. Furthermore, since suicide prevention contracts are dependent on an established physician-patient relationship, they are not recommended for use in emergency settings or with newly admitted or unknown inpatients **[II]**.

Despite best efforts at suicide assessment and treatment, suicides can and do occur in clinical practice. When the suicide of a patient occurs, the psychiatrist may find it helpful to seek support from colleagues and obtain consultation or supervision to enable him or her to continue to treat other patients effectively and respond to the inquiries or mental health needs of survivors **[II]**. Consultation with an attorney or a risk manager may also be useful **[II]**. The psychiatrist should be aware that patient confidentiality extends beyond the patient's death and that the usual provisions relating to medical records still apply. Any additional documentation included in the medical record after the patient's death should be dated contemporaneously, not backdated, and previous entries should not be altered **[I]**. Depending on the circumstances, conversations with family members may be appropriate and can allay grief **[II]**. In the aftermath of a loved one's suicide, family members themselves are more vulnerable to physical and psychological disorders and should be helped to obtain psychiatric intervention, although not necessarily by the same psychiatrist who treated the individual who died by suicide **[II]**.

Specific Treatment Modalities

In developing a plan of treatment that addresses suicidal thoughts or behaviors, the psychiatrist should consider the potential benefits of somatic therapies as well as the potential benefits of psychosocial interventions, including the psychotherapies **[I]**. Clinical experience

	indicates that many patients with suicidal thoughts, plans, or behaviors will benefit most from a combination of these treatments **[II]**. The psychiatrist should address the modifiable risk factors identified in the initial psychiatric evaluation and make ongoing assessments during the course of treatment **[I]**. In general, therapeutic approaches should target specific axis I and axis II psychiatric disorders; specific associated symptoms such as depression, agitation, anxiety, or insomnia; or the predominant psychodynamic or psychosocial stressor **[I]**. While the goal of pharmacologic treatment may be acute symptom relief, including acute relief of suicidality or acute treatment of a specific diagnosis, the treatment goals of psychosocial interventions may be broader and longer term, including achieving improvements in interpersonal relationships, coping skills, psychosocial functioning, and management of affects. Since treatment should be a collaborative process between the patient and clinician(s), the patient's preferences are important to consider when developing an individual treatment plan **[I]**.
NZGG (2003)	**Crisis/Initial Management** By the end of the assessment, there must be a clearly documented management plan that specifically includes a safety strategy. The key components of the treatment plan should be: • To ensure the safety of the person. The immediate goal of management is preventing a person in crisis from committing suicide until that crisis has passed. To that end, an early decision needs to be made on whether or not to admit to an inpatient unit. • To establish an effective therapeutic relationship-creating a sense of meaningful assistance. • To institute effective treatment of any mental illness and address whatever may have precipitated the person's distress. **D** The presence of a "safety contract" does not in any way guarantee the person's actual safety. There is no evidence that it acts as a deterrent to suicide. **Management as an Outpatient** **A** Providing people with "green cards" (24-hour access to a crisis team) is a useful but insufficient treatment strategy, and other interventions should also be provided. Many people with suicidal ideation can be treated successfully as an outpatient. [1] In such circumstances, the following treatment measures should be put into place. • Increase the frequency of outpatient visits and between-visit

telephone contacts. [4]

- Assess the degree of risk at every contact, including evaluation of the need for hospitalisation or respite options in an ongoing way [4]
- Ensure that the person has access to 24-hour emergency support (give the number for the crisis assessment and treatment team/psychiatric emergency team). [1+]
- Review the treatment plan regularly and revise as needed if risk level changes. [4]
- Consult with colleagues or multidisciplinary teams. [4]
- Consult with whānau/family/support people where appropriate. [4]

The Decision to Hospitalise

D The following people with suicidal ideation should be admitted when:

- they are acutely suicidal
- medical management of an attempt is required
- they require more intensive psychiatric management
- the establishment of a treatment alliance and crisis intervention fails and the person remains acutely suicidal

D When no suitable caregivers/support people are available, respite care options may be considered as an alternative to admission.

A In order to reduce the person's risk of suicide, admission should be for more than 4 days.

C For a chronically suicidal person short admissions (1- 4 days) may be appropriate.

GPP If the person is not admitted, appropriate arrangements must be made for timely follow-up with the relevant health provider (e.g., care manager, therapist) within 24 hours.

GPP The reasons for not admitting must be clearly documented in the person's file.

Management as an Inpatient

GPP People assessed as being at high risk of suicide should be under close supervision. (See Appendix 6 in the original guideline document for guidelines for supervision.)

GPP The level of support and observation should reflect the person's changing suicide risk.

C Inpatient unit staff need to be vigilant, particularly when the

person is not well-known and for the first week after admission.

D Treatment (both psychopharmacological and psychological) of underlying mental illnesses should be initiated as early as possible.

Discharge Planning

A Follow-up should occur in the first week post-discharge, as this is the highest risk time for a person discharged from hospital. This should happen even if the person fails to attend their outpatient appointment.

D If the person does not attend their follow-up appointment and is believed to still have a significant risk of suicide, the clinician must make efforts to contact that person immediately to assess their risk of suicide or self-harm.

GPP The discharge plan should be developed in consultation with the person and their key support people (including whānau/family if appropriate) and clinicians.

GPP Before leaving the hospital the person should have a clear understanding of discharge arrangements that have been made and a written copy with information about medication, treatment plans, and key contacts to call, if needed.

GPP If appropriate, the person's whānau/family or nominated next-of-kin should be informed of the person's risk, told of their next appointment, and invited to attend. They should also be involved in discharge planning processes.

GPP The continuing care provider/team must get at least a verbal report prior to discharge. They should also be included in any discharge planning meetings/decision-making processes.

GPP The person's general practitioner should also get a full copy of the discharge plan, including any medication recommendations. If the general practitioner is the sole care provider, he/she should receive this prior to the person's discharge from hospital.

Intervention/Treatment Strategies

A Follow-up by the same therapist across inpatient and outpatient settings results in people at risk of suicide being more likely to agree to take medication and to attend appointments.

The Challenge of Working with People who Self-harm or Attempt Suicide

GPP All clinicians who work with people who self-harm or are

suicidal should be in regular clinical supervision to mitigate the negative impact that this work can have both on them and on the quality of their work with suicidal people.

Assessment and Crisis Management with Special Populations

Children and Adolescents

D The assessment of suicidal young people should be carried out by a clinician who is skilled in interviewing and working with children and adolescents whenever possible.

D Self-harm among children is rare and should be treated very seriously.

GPP Risk assessments should draw on information from multiple sources, including the young person, their teachers/guidance counselors, parents etc.

The Elderly

GPP Any elderly person who is expressing suicidal ideation or has presented following an attempt should be treated very seriously. The clinician should consider whether the symptoms could be related to self-neglect or reflect a passive death wish.

GPP Clinicians should treat symptoms of depression in an older person assertively. If depression and/or suicidality is suspected, physical causal factors need to be ruled out.

GPP Assessments should also draw on information from relatives or friends who can comment on whether the person is different from "their usual self."

Māori

GPP Assessment of Māori people requires consideration of their cultural context and meaning associated with their identity as Māori. Specialist Māori input is important when cultural issues or issues of identity arise among tāngata whaiora. Māori people who are suicidal should be offered the input of specialist Māori mental health workers.

GPP People's preference should be sought and respected for involving whānau or support of others in assessment and developing a treatment/management plan.

Pacific Peoples

GPPM Assessment of Pacific peoples requires consideration of their Pacific cultural contexts and beliefs. Specialist Pacific input is important when cultural issues or issues of breaches of protocol are present among Pacific peoples. Pacific peoples who are suicidal should be offered the input of specialist Pacific mental health workers.

GPP Pacific peoples' preference should be sought and respected for involving family or support of others (e.g., church leaders, traditional healers) in assessment and developing a treatment/management plan.

GPP Language barriers may be an issue for some Pacific peoples. Care must be taken in ensuring confidentiality when interpreters are used due to the small size of Pacific communities and the shame associated with suicide and attempted suicide among Pacific peoples.

People of Indian Descent

GPP Indian people come from many diverse cultures, and assessment should acknowledge their specific cultural contexts and beliefs.

GPP Indian people consider family roles and obligations of primary importance, and assessment should acknowledge their needs within the context of their family.

GPP Problem-solving, psycho-education, and the use of trusted intermediaries can help counter some of the shame or "loss of face" associated with mental illness.

Asian Populations

GPP Cultural values and beliefs vary depending on the person's subculture and degree of acculturation to Western values. Even if the person identifies themselves as a New Zealander, it is still important to check the cultural values of their family and significant others, as a gap in views can be a source of stress.

GPP Language barriers may be an issue for some Asian people. Care must be taken in ensuring confidentiality when interpreters are used due to the small size of Asian communities.

GPP When working with someone from an Asian community the clinician should consult culturally appropriate services to assist in intervening in helpful ways.

Refugee Groups

GPP Refugees are most likely to have been victims of some level of

	trauma. They may be distrustful of official agencies and health systems. Clinicians need to proceed respectfully and carefully, explaining the intention behind any action and potential consequences for the person. Clinicians should not push for accounts of past trauma experiences, and may need to focus more on the "here and now." **GPP** If an interpreter is needed, care must be taken over confidentiality issues as many of the communities are small and people may know each other. **GPP** Serious consideration should be given to referring refugees with mental health difficulties to specialist agencies such as Refugees as Survivors. **Assessment and Management of Chronically Suicidal People** **C** Detailed management plans that list both chronic and acute symptoms should be developed with the person. This assists clinicians in determining whether a person is presenting with new/greater risk than their ongoing risk. All services working with this person should have a copy of these plans, and they should be regularly reviewed and updated. **C** Emergency departments should always contact mental health services (even if only by phone) when a chronically suicidal person presents. Care must be taken not to downplay the seriousness of attempts. **D** When a person who is well-known to the service arrives at the emergency department, it is crucial that their file is obtained, their management plan consulted, and ideally their case manager or therapist contacted in case they are now suffering from additional stressors or a significant change in their mental illness(es). **D** Inpatient admission or referral to high support services (such as crisis respite) may be necessary when the person's suicidality is exacerbated by an acute life stressor, or if they also develop an Axis I disorder.
Pharmacologic Therapy	
APA (2003)	**Somatic Interventions** Evidence for a lowering of suicide rates with antidepressant treatment is inconclusive. However, the documented efficacy of antidepressants in treating acute depressive episodes and their long-term benefit in patients with recurrent forms of severe anxiety or depressive disorders support their use in individuals with these disorders who are experiencing suicidal thoughts or behaviors **[II]**.

	It is advisable to select an antidepressant with a low risk of lethality on acute overdose, such as a selective serotonin reuptake inhibitor (SSRI) or other newer antidepressant, and to prescribe conservative quantities, especially for patients who are not well-known **[I]**. For patients with prominent insomnia, a sedating antidepressant or an adjunctive hypnotic agent can be considered **[II]**. Since antidepressant effects may not be observed for days to weeks after treatment has started, patients should be monitored closely early in treatment and educated about this probable delay in symptom relief **[I]**. To treat symptoms such as severe insomnia, agitation, panic attacks, or psychic anxiety, benzodiazepines may be indicated on a short-term basis **[II]**, with long-acting agents often being preferred over short-acting agents **[II]**. The benefits of benzodiazepine treatment should be weighed against their occasional tendency to produce disinhibition and their potential for interactions with other sedatives, including alcohol **[I]**. Alternatively, other medications that may be used for their calming effects in highly anxious and agitated patients include trazodone, low doses of some second-generation antipsychotics, and some anticonvulsants such as gabapentin or divalproex **[III]**. If benzodiazepines are being discontinued after prolonged use, their doses should be reduced gradually and the patient monitored for increasing symptoms of anxiety, agitation, depression, or suicidality **[II]**. There is strong evidence that long-term maintenance treatment with lithium salts is associated with major reductions in the risk of both suicide and suicide attempts in patients with bipolar disorder, and there is moderate evidence for similar risk reductions in patients with recurrent major depressive disorder **[I]**. Specific anticonvulsants have been shown to be efficacious in treating episodes of mania (i.e., divalproex) or bipolar depression (i.e., lamotrigine), but there is no clear evidence that their use alters rates of suicide or suicidal behaviors **[II]**. Consequently, when deciding between lithium and other first-line agents for treatment of patients with bipolar disorder, the efficacy of lithium in decreasing suicidal behavior should be taken into consideration when weighing the benefits and risks of treatment with each medication. In addition, if lithium is prescribed, the potential toxicity of lithium in overdose should be taken into consideration when deciding on the quantity of lithium to give with each prescription **[I]**. Clozapine treatment is associated with significant decreases in rates of suicide attempts and perhaps suicide for individuals with schizophrenia and schizoaffective disorder. Thus, clozapine treatment should be given serious consideration for psychotic patients with frequent suicidal ideation, attempts, or both **[I]**. If treatment is indicated with an antipsychotic other than clozapine, the other second-generation antipsychotics (e.g., risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole) are preferred over

	the first-generation antipsychotic agents **[I]**.
NZGG (2003)	**Sedation** **C** Acute sedation with medication may be necessary if the person shows violent or agitated behaviour or symptoms of psychosis. Consider prescribing an antipsychotic (such as haloperidol) or a short- to medium-term benzodiazepine (such as lorazepam which has a short half-life, or clonazepam which is presently the only intra-muscular benzodiazepine available). A full assessment must then be resumed. **A** Haloperidol is contraindicated where the person is depressed or has central nervous system (CNS) depression due to drugs or alcohol. **GPP** Haloperidol can cause painful dystonic reactions for some people, particularly among people who have never taken an antipsychotic before. In such cases, the co-prescription of an anticholinergic agent (such as benztropine) is advised. The newer antipsychotic medications have not yet been formally evaluated for use in this setting. **GPP** Benzodiazepines should only be used for sedation as a short-term measure. They must be administered under supervision. **GPP** Check for allergic reactions to some sedating drugs. Ask the person or obtain file notes. **GPP** If a person has been sedated and then needs to be transported to another place for assessment, medical support must be provided during transit. The accompanying clinician needs to be aware of potential medical complications of sedation (e.g., respiratory arrest following intravenous benzodiazepine use). **Intervention/Treatment Strategies** **A** Follow-up by the same therapist across inpatient and outpatient settings results in people at risk of suicide being more likely to agree to taking medication and to attend appointments. **Prescribing Issues** **C** Clinicians should be cautious when prescribing benzodiazepines (both acutely and in the medium-term), especially if the person may also be suffering from depression or have risk factors for suicide. **C** Clinicians need to monitor suicide risk closely irrespective of the antidepressant/drug used. This is essential both to rule out any paradoxical increase in suicidality and also to ensure that risk does

	not increase as the treatment begins to work, relieving the motor symptoms and lack of drive first, but not the mood related symptoms. **GPP** In general, if a person is suspected of being at risk of suicide, appropriate medications should be prescribed and dispensed in dosages and quantities that are less likely to be lethal in overdose or in combination with other drugs or alcohol.
Electroconvulsive Therapy (ECT)	
APA (2003)	Electroconvulsive therapy (ECT) has established efficacy in patients with severe depressive illness, with or without psychotic features. Since ECT is associated with a rapid and robust antidepressant response as well as a rapid diminution in associated suicidal thoughts, ECT may be recommended as a treatment for severe episodes of major depression that are accompanied by suicidal thoughts or behaviors **[I]**. Under certain clinical circumstances, ECT may also be used to treat suicidal patients with schizophrenia, schizoaffective disorder, or mixed or manic episodes of bipolar disorder **[II]**. Regardless of diagnosis, ECT is especially indicated for patients with catatonic features or for whom a delay in treatment response is considered life threatening **[I]**. ECT may also be indicated for suicidal individuals during pregnancy and for those who have already failed to tolerate or respond to trials of medication **[II]**. Since there is no evidence of a long-term reduction of suicide risk with ECT, continuation or maintenance treatment with pharmacotherapy or with ECT is recommended after an acute ECT course **[I]**.
NZGG (2003)	No recommendations offered
Psychosocial Therapy	
APA (2003)	**Psychosocial Interventions** Psychotherapies and other psychosocial interventions play an important role in the treatment of individuals with suicidal thoughts and behaviors **[II]**. A substantial body of evidence supports the efficacy of psychotherapy in the treatment of specific disorders, such as nonpsychotic major depressive disorder and borderline personality disorder, which are associated with increased suicide risk. For example, interpersonal psychotherapy and cognitive behavior therapy have been found to be effective in clinical trials for the treatment of depression. Therefore, psychotherapies such as interpersonal psychotherapy and cognitive behavior therapy may be considered appropriate treatments for suicidal behavior, particularly when it occurs in the context of depression **[II]**. In addition, cognitive behavior therapy may be used to decrease two important

	risk factors for suicide: hopelessness **[II]** and suicide attempts in depressed outpatients **[III]**. For patients with a diagnosis of borderline personality disorder, psychodynamic therapy and dialectical behavior therapy may be appropriate treatments for suicidal behaviors **[II]**, because modest evidence has shown these therapies to be associated with decreased self-injurious behaviors, including suicide attempts. Although not targeted specifically to suicide or suicidal behaviors, other psychosocial treatments may also be helpful in reducing symptoms and improving functioning in individuals with psychotic disorders and in treating alcohol and other substance use disorders that are themselves associated with increased rates of suicide and suicidal behaviors **[II]**. For patients who have attempted suicide or engaged in self-harming behaviors without suicidal intent, specific psychosocial interventions such as rapid intervention; follow-up outreach; problem-solving therapy; brief psychological treatment; or family, couples, or group therapies may be useful despite limited evidence for their efficacy **[III]**.
NZGG (2003)	**Intervention/Treatment Strategies** • Longer-term therapy to treat any underlying mental illnesses (including substance abuse) is crucial. • Both Cognitive-Behavioural Therapy and Interpersonal Psychotherapy were shown to be promising therapeutic interventions for reducing the probability of deliberate self-harm and also symptoms of depression among people who attended an emergency department for a suicide attempt. (1-). • Dialectical Behavioural Therapy has also been shown to be promising for reducing suicide and self-harm attempts among people with Borderline Personality Disorder while they are in therapy (1+/1) **A** Follow-up by the same therapist across inpatient and outpatient settings results in people at risk of suicide being more likely to agree to taking medication and to attend appointments.

Selected Supporting References

Note from NGC: Refer to the original guideline document for a complete listing of supporting references.

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TABLE 5: BENEFITS AND HARMS	
Benefits	
APA (2003)	• Increased understanding of suicide risk and intervention by psychiatric professionals • Decreased rates of suicide • Decreased rates of suicide attempts • Improved control of symptoms related to suicidal ideation and

	behaviors Refer to the original guideline document for the evidence synthesis related to specific interventions.
NZGG (2003)	Appropriate management and intervention with people who have made a suicide attempt with the intent (or partial intent) of ending their lives and those who are at risk of taking their own lives
Harms	
APA (2003)	See the original guideline document for discussion of some of the side effects associated with drugs used to manage individuals with suicidal ideation and behavior.
NZGG (2003)	See the original guideline document for discussion of some of the side effects associated with drugs used to manage individuals with suicidal ideation and behavior.

TABLE 6: EVIDENCE RATING SCHEMES AND REFERENCES	
APA (2003)	Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendation: [I] Recommended with substantial clinical confidence [II] Recommended with moderate clinical confidence [III] May be recommended on the basis of individual circumstances **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS** The recommendations are based on the best available data and clinical consensus with regard to a particular clinical decision. The summary of treatment recommendations is keyed according to the level of confidence with which each recommendation is made (see the "Major Recommendations" field). In addition, the following coding system is used to indicate the nature of the supporting evidence in the references: [A] *Randomized, double blind clinical trial* A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; both the subjects and the investigators are "blind" to the

	assignments [A--] *Randomized clinical trial* Same as above but not double blind [B] *Clinical trial* A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally; study does not meet standards for a randomized clinical trial [C] *Cohort or longitudinal study* A study in which subjects are prospectively followed over time without any specific intervention [D] *Case-control study* A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time [E] *Review of secondary analysis* A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis [F] *Review A* qualitative review and discussion of previously published literature without a quantitative synthesis of the data [G] *Other* Textbooks, expert opinion, case reports, and other reports not included above
NZGG (2003)	**Levels of Evidence** **1++** High quality meta-analyses/systematic reviews of randomised controlled clinical trials (RCTs), or RCTs with a very low risk of bias **1+** Well-conducted meta-analyses/systematic reviews, or RCTs with a low risk of bias **1-** Meta-analyses/systematic reviews, or RCTs with a high risk of bias **2++** High quality systematic reviews of case-control or cohort studies High quality case-control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+

Well-conducted case-control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2-

Case-control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3

Non-analytic studies (e.g., case reports). Case series

4

Expert opinion

Qualitative material was systematically appraised for quality, but was not ascribed a level of evidence.

Grades of Recommendations

A

At least one meta-analysis, systematic review, or randomised, controlled clinical trial (RCT) rated 1++ and directly applicable to the target population

or

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B

A body of evidence consisting principally of studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results

or

Extrapolated evidence from studies rated as 1++, or 1+

C

A body of evidence consisting principally of studies rated as 2+, directly

	applicable to the target population, and demonstrating overall consistency of results or Extrapolated evidence from studies rated as 2++ **D** Evidence level 3 or 4 or Extrapolated evidence from studies rated as 2+ Additionally, **Good Practice Points** are recommended as the best practice based on the clinical experience of the guideline development team.

GUIDELINE CONTENT COMPARISON

The American Psychiatric Association (APA) and the New Zealand Guidelines Group (NZGG) present recommendations for management of individuals with suicidal ideation and/or behavior and provide explicit reasoning behind their judgments, ranking the level of evidence for each major recommendation.

There are important differences in the general focus of the guidelines. The APA guideline is directed at psychiatrists and other physicians and includes considerable detail concerning assessment and both initial and long-term management of the person at risk for suicide. In contrast, the NZGG guideline primarily addresses assessment and initial management in acute care settings such as emergency departments and acute psychiatric services settings, with referral to mental health services for further assessment and management as appropriate. The NZGG guideline only minimally addresses long-term management of the patient at risk for suicide.

Guideline Development Methodology

Both organizations performed a systematic review of the literature that included applying quality criteria to published studies to select those suitable for evidence review and guideline formulation. A description of the methods used to collect and search the literature (e.g., search strategies and search terms) is included for both organizations. NZGG also provides inclusion/exclusion criteria, APA and NZGG both describe relevant information about the electronic databases they searched and the time range over which data were obtained. A systematic literature review was prepared by the New Zealand Health Technology Assessment (NZHTA) for the NZGG guideline.

With regard to the review of the evidence, APA presents its arguments and rationale, along with references to supporting evidence, in a narrative format. APA also includes an executive summary of recommendations (also in narrative format) at the beginning of the guideline. NZGG includes recommendation statements both at the beginning and throughout the guideline, supported by narrative discussion with references to the evidence. Both groups performed a Review of Published Meta-Analyses and a Systematic Review with Evidence Tables as methods of analyzing the evidence.

Both groups provide reference lists (846 references for APA, 89 for NZGG), and both groups cite the supporting evidence in their narrative discussions, rather than linking it directly to the recommendation statements. For both groups, the strength of each recommendation statement is graded accorded to a rating scheme. Also using a rating scheme, NZGG denotes the quality of the supporting evidence in the narrative discussion. Although APA does not employ a rating scheme for the strength of evidence, it uses a coding system to indicate the nature of the supporting evidence in the list of references.

APA and NZGG both disclose potential conflicts of interest.

Suicidal Ideation and Behavior: Comparison of Recommendations Between the APA and NZGG Guidelines	
APA (2003)	**NZGG (2003)**
• APA recommends psychiatric management, which includes: attending to patient safety, determining a setting for treatment and supervision, and working to establish a cooperative and collaborative physician-patient relationship. For patients in ongoing treatment, psychiatric management also includes establishing and maintaining a therapeutic alliance; coordinating treatment provided by multiple clinicians; monitoring the patient's progress and response to the treatment plan; and conducting ongoing assessments of the patient's safety, psychiatric status, and level of functioning	• NZGG recommends a clearly documented survival plan that specifically includes a safety strategy. The key components of the treatment plan should be: ensuring the safety of the person, establishing an effective therapeutic relationship (creating a sense of meaningful assistance), and instituting effective treatment of any mental illness and address whatever may have precipitated the person's distress.
• Cites pharmacologic agents, psychotherapies and	• Cites pharmacologic agents and psychotherapies as possible

electroconvulsive therapy (ECT) as possible treatment options	treatment options

Areas of Agreement

Management

The guidelines generally agree that there is insufficient evidence to recommend specific treatments to reduce suicide risk. However, there is agreement that management strategies should focus on measures to support patient safety, identification of underlying disorders and psychosocial stressors, and implementation of appropriate intervention strategies to mitigate or treat underlying disorders and stressors.

Both APA and NZGG emphasize the need to establish rapport with the patient in order to form a therapeutic alliance. The guidelines emphasize the importance of understanding the patient's cultural and religious values as part of the effort to establish a therapeutic alliance. NZGG recommends the involvement of culturally appropriate services for assessment, crisis management, and service liaison when possible and provides specific recommendations related to management of suicide risk in Māori, Pacific peoples, people of Indian descent, Asian populations, and refugee groups.

The guidelines are in general agreement that suicide prevention or safety contracts are not useful in the emergency setting or for crisis or initial management of suicide risk. APA states that such contracts are dependent on an established physician-patient relationship. According to NZGG, there is no evidence that these contracts act as a deterrent to suicide. Refer to the original APA guideline document for further discussion about the use of these types of contracts.

APA states that there is limited evidence that specific forms of psychiatric treatment reduce suicide risk, but the best evidence relates to psychopharmacological treatments for major affective and psychotic disorders. Refer to the original guideline document for a review of the evidence related to antidepressants, lithium, and "mood stabilizing" anticonvulsant, antipsychotic and antianxiety agents. NZGG does not discuss psychopharmacological treatments in detail, but notes that appropriate medications should be prescribed as part of the treatment of any underlying mental illness and clinicians should monitor a person's suicide risk closely as they respond to medication.

APA and NZGG consider various psychological therapies, with the APA guideline discussing the options in greatest detail. Both APA and NZGG conclude there is some evidence that certain psychoanalytic, psychodynamic and cognitive behavior therapies can be beneficial. In addition, both guidelines agree that dialectical behavior therapy may reduce risk for suicide and self-harm in patients with borderline personality disorder.

Areas of Differences

Management

NZGG does not discuss electroconvulsive therapy (ECT), but APA concludes that ECT may provide rapid short-term benefits against suicidal thinking; longer-term benefits have not been seen. Apart from this topic, there are no major differences between the guidelines concerning management of the patient at risk for suicide.

Conclusion

A comprehensive psychiatric evaluation having been completed, both guidelines stress the need for determination of an appropriate treatment setting, an effective treatment plan, and for an effective therapeutic alliance between patient and physician. Both recommend pharmacological agents and psychotherapies as first-line therapies for suicidal ideation and/or behavior.

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